

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REHAB OBJECTION

Instructions: Use this form to object to Forms WC-R1, WC-R1CATEE, WC-R2A, or WC-R3. This form must be filed 20 days from the date of the certificate of service.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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A. IDENTIFYING INFORMATION					
EMPLOYEE	County of Injury		Address		
	Employee E-mail		City	State	Zip Code
EMPLOYER	Name		INSURER/ SELF-INSURER		
	Address		CLAIMS OFFICE		
City		State	Zip Code	Address	
Employer E-mail		City		State	Zip Code
		Claims Office E-mail			
ATTORNEY FOR EMPLOYEE /CLAIMANT	Name		ATTORNEY FOR EMPLOYER/INSURER		
	Address		Address		
City		State	Zip Code	City	
GA Bar Number		GA Bar Number			
Attorney E-mail		Attorney E-mail			

B. OBJECTION TO:	
*** An argument must be attached in support of your position ***	
Submitted By: <input type="checkbox"/> Claimant <input type="checkbox"/> Employer/Insurer (Check One)	
<input type="checkbox"/> 1. WC-R1CATEE	<input type="checkbox"/> 2. WC-R1
<input type="checkbox"/> 3. WC-R2A	<input type="checkbox"/> 4. WC-R3
<input type="checkbox"/> 5. OTHER Specify:	

C. CERTIFICATE OF SERVICE		
<input type="checkbox"/> I hereby certify that I have today sent a copy of this form to all of the parties named above and to any/all involved rehabilitation suppliers, and have sent this form to the State Board of Workers' Compensation, 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299		
Print Name	Signature	Date
Phone Number and Ext		E-Mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).